



County of San Diego

DEPARTMENT OF ENVIRONMENTAL HEALTH

HAZARDOUS MATERIALS DIVISION

P.O. BOX 129261, SAN DIEGO, CA 92112-9261

(619) 338-2222 FAX (619) 338-2377

1-800-253-9933

APPLICATION FOR STEAM STERILIZATION ON-SITE MEDICAL WASTE TREATMENT PERMIT

Dear Business Owner/Operator:

If your medical facility generates and treats 200 pounds or more of medical waste in any calendar month, you are required to obtain an On-Site Medical Waste Treatment Permit from the Certified Unified Program Agency (CUPA).

To comply with this requirement you must complete the enclosed application and pay an initial 2-hour review fee. Please call the Hazardous Materials Duty Desk at 619-338-2231 for the current hourly rate. Make your check payable to: COUNTY OF SAN DIEGO. If additional processing hours are accrued, you will receive an invoice. Fees must be paid in full before the permit is issued.

Send your completed application attached with your payment to:

**County of San Diego
Department of Environmental Health
Hazardous Materials Division
ATTN: Medical Waste Coordinator
P.O. Box 129261
San Diego, CA 92112-9261**

Your permit is valid for 5 years. You must notify the Hazardous Materials Division (HMD) of any changes that may occur during this time. To renew this permit you must submit a completed On-Site Medical Waste Treatment Permit application at least 90 days prior to the expiration date on the current permit.

State law specifies that an application for a treatment facility must be submitted and approved to operate a medical waste treatment unit. Failure to obtain a medical waste treatment permit is a violation and subject to a penalty of up to \$2,000 or one year in county jail, or both.

If you have any questions, please call the Hazardous Materials Duty Desk at (619) 338-2231.

UPFP: _____

MEDICAL WASTE TREATMENT PERMIT APPLICATION

Date application was received: ____ / ____ / ____

Name of Facility: _____

Facility's Contact Person(s)

Phone Number

Last First M.I.

() _____

Last First M.I.

() _____

Facility's Address: _____

Street No. Street Name City State Zip Code

Mailing Address

(if different from above): Street No. Street Name City State Zip Code

FACILITY STATUS

Place an "X" on the appropriate line to indicate whether this application is for a new or existing facility.

☐ New Facility

☐ Existing Facility

If an existing facility, please indicate the purpose of this application. Place an "X" on the appropriate line below to indicate whether this is a renewal application, a facility modification, transfer of ownership, revised application, or an initial request for a permit.

☐ a. Initial Request for a Permit

☐ b. Modification

☐ c. Transfer of Ownership

☐ d. Permit Revision

☐ e. Permit Renewal

APPLICATION INFORMATION (Note: Provide the information requested below on a separate page attached to the completed application).

A. Estimated Weight and Volume

1. Average monthly quantity of medical waste to be stored and/or treated at this facility.
2. The rated capacity per operational cycle, the time per cycle, the number of operating hours per day, and the days per week of operation.
3. Type and description of medical waste being treated. What measures will be employed to prevent unauthorized waste (i.e. chemical waste, chemotherapy waste, etc.) from being treated at the facility.

UPFP: _____

B. Compliance History

A description of your compliance history relative to local, state or federal regulations regarding the handling, storage, or treatment of medical waste during the previous three years. Include information from other facilities under your control for the same period.

FACILITY OWNER

Name of legal owner of facility

Phone Number

Last

First

M.I.

() _____

Address: _____

Street or P.O. Box No.

Street Name

City

State

Zip Code

MEDICAL WASTE TREATMENT EQUIPMENT SPECIFICATIONS

Each medical waste treatment unit must be described below. The following information shall be completed and submitted along with the application. Submit a separate sheet for each medical waste treatment unit.

Must complete the following information: (please print or type information)

1. Date of equipment installation: _____ / _____ / _____
2. Manufacturer's Name: _____
3. Model Number: _____
4. Serial Number: _____
5. Provide the exact location and/or room number where the treatment unit will be operated:

6. Provide the rated capacity of the treatment unit: _____ pounds/hour of waste treated.
7. Provide the date when the treatment equipment was last serviced by a "manufacturer-authorized" technician: _____ / _____ / _____

UPFP: _____

EMERGENCY ACTION PLAN

Attach a copy of your Emergency Action Plan with this application.

TRAINING PLAN

Attach a copy of your employee Training Plan for medical waste management with this application.

CLOSURE PLAN

Attach a copy of your Closure Plan and a written estimate of the cost of closing the medical waste storage and treatment areas.

SIGNATURE CERTIFICATION

Owner and operator certification:

I certify under penalty of perjury that this document and all the attachments have been prepared under my direction and supervision in accordance with a system to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those directly responsible for gathering the information, the information is to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment.

Owner's Name (print or type): _____

Signature: _____

Date: ____ / ____ / ____